Agency:	**107 Health Care Authority**
Decision Package Code/Title:	**PL-N2 Support HealthPath Washington**
Budget Period:	**2015-17 Biennial Submittal**
Budget Level:	**PL – Policy Level**

Recommendation Summary Text

The Health Care Authority (HCA) requests a reduction of $30,648,000 total funds and an additional 3.5 FTEs in the 2015-17 biennium for the Health Home and HealthPath Washington programs. This represents an increase of $13,526,000 GF-State and a reduction of $44,174,000 GF-Federal. The staffing requested are currently grant funded. After grant funding ends they will continue to provide program management, support to contractors and providers, and to assure program outcomes of improved health, reduced cost and improved quality of care.

Package Description

The HCA and the Department of Social and Health Services (DSHS) have prepared a joint update to the February 2014 report on progress on implementing the Health Home and HealthPath Washington programs.

Background on the Health Home Model

Under Washington State's approach, the health home program is the bridge to integrate care within existing care systems for high-risk, high-cost adults and children, including dual eligibles. A health home is the central point for directing person-centered care and is accountable for:

- Reducing health care costs, specifically hospital; admissions/readmissions and emergency department visits;
- Providing timely post discharge follow-up; and
- Improving patient outcomes by mobilizing and coordinating primary medical, specialist, behavioral health and long-term care services and supports.

Care Coordinators must be embedded in community based settings to effectively manage the full breadth of beneficiary needs. Washington has four high level goals for the health home program:

- Improve the beneficiary's clinical outcomes;
- Improve the beneficiary's self-management abilities;
- Improve health care quality and promote efficient and evidence-based health care service delivery; and
- Reduce future cost trends or at the very least attain cost neutrality with improved outcomes.

The foundation of the State's health homes is the community network, which must be present in order to qualify as a Health Home. Partnerships across mental health and substance abuse providers, long-term services and supports providers and the medical community are developed to support care coordination and access through integrated health home services. The beneficiary is involved in their improving their health through the development their Health Action Plan. Beneficiaries may choose to include their families and caregivers as part of their health home team.

The Health Home program has been successful in achieving several milestones:

- 3,450 high-risk, high cost beneficiaries have been engaged in health home activities. Evidence based screenings and interventions are being implemented with beneficiaries receiving health home services. In part this strategy was implemented to provide a model of

care based on attaining core outcomes, but also to target improved beneficiary self-management and confidence in working with health and social service providers to improve health, reduce cost and improve the quality of care.

- Over 300 Care Coordination Organization staff have received Health Home training, including many who provide services to the highest risk Medicaid and dually eligible beneficiaries.
- The establishment of a network of Health Home Lead Entities and Care Coordination Organizations supports the broad goals established in the State Health Care Innovation Plan including Accountable Communities of Health, Behavioral Health Organizations, and Fully Integrated physical health/behavioral health plans. Community based organizations have new skills in cross systems care coordination because of their involvement in the Health Home program.
- Recruitment and retention of Care Coordination Organizations and Care Coordinators is one of the key elements to providing community based care coordination services. All partners in this program are working collaboratively to establish relationships with non-traditional health and social service providers to deliver person centered care.
- In keeping with the State Health Care Innovation Plan, which includes the prominent role for Community Health Workers, affiliated staff working with Care Coordinators include Community Health Workers (CHWs) and Peer Counselors.

As reported in February, the initial implementation experienced challenges relating to bringing up a new, complex program. At this point, the system issues and technical aspects of enrollment and reporting have largely been resolved. The remaining issues of client outreach and engagement are common to most efforts that involve high-risk low-income beneficiaries, due to the competing demands on their time to ensure that basic needs are met. An interim report, scheduled to be completed in October, will outline strategies to address those issues and improve the sustainability of the program.

Background on HealthPath Washington

The implementation of HealthPath Washington, the fully integrated capitated model for adults eligible for both Medicare and Medicaid, has been delayed until July 2015. Since April, when rates were presented to the two "apparently successful bidders," the State has been negotiating with the health plans to come to agreement on acceptable rates. CMS rules for rate-setting have proven particularly onerous for HealthPath Washington. For example:

- The administrative overhead costs are limited to any administrative costs that would be avoided by enrolling in managed care (e.g. the 2% of the claims costs related to processing claims through HCA, or the case management costs once initial assessment is completed by staff in Aging and Long-Term Services Administration).
- In addition, for the first time Medicare's capitation rates are based on current fee-for-service payments, as opposed to the way rates are set for Medicare Advantage Special Needs Plans.
- Finally, the final blended rates are discounted by a gradually increasing percentage for performance, and a savings adjustment that also increases over the course years of the demonstration. In Washington, the B&O tax, the MCO premium tax of 2% and the WSHIP

assessment would discount the rates to an untenable level, which is why HCA and DSHS are requesting an exemption for those taxes.

Agreement has now been reached on the rates by United Healthcare and Community Health Plan of Washington now moving forward toward contracting. The compromise resulted in slightly lower savings returning to the State, as the savings percent is now 1.0percent for the first period of demonstration (through 2016), and 1.5percent for years two and three. The health plans have stated that they will withdraw from the demonstration if the exemption is not passed by the legislature.

Several steps remain prior to beginning enrollment: final contract approval by CMS; completing readiness review, which includes provider network analysis and a site visit by CMS contractors and state staff; finishing the Provider One system changes; educating providers and beneficiaries about the opportunity to enroll in the new program, etc. Because these have been put on hold during the rates negotiation, the start has been delayed to July 2015.

Questions related to this request should be directed to Christy Vaughn at (360) 725-0468 or at Christy.Vaughn@hca.wa.gov.

Fiscal Detail/Objects of Expenditure

	FY 2016	FY 2017	Total
1. Operating Expenditures:			
Fund 001-1 GF-State	$ 8,719,000	$ 4,807,000	$ 13,526,000
Fund 001-C GF-Federal Medicaid Title XIX	$(20,131,000)	$(24,043,000)	$(44,174,000)
Total	**$(11,412,000)**	**$(19,236,000)**	**$(30,648,000)**

	FY 2016	FY 2017	Total
2. Staffing:			
Total FTEs	2.0	5.0	3.5

	FY 2016	FY 2017	Total
3. Objects of Expenditure:			
A - Salaries And Wages	$ 162,000	$ 453,000	$ 615,000
B - Employee Benefits	$ 49,000	$ 136,000	$ 185,000
C - Personal Service Contracts	$ -	$ -	$ -
E - Goods And Services	$ 26,000	$ 70,000	$ 96,000
G - Travel	$ 1,000	$ 3,000	$ 4,000
J - Capital Outlays	$ -	$ -	$ -
N - Grants, Benefits & Client Services	$(11,654,000)	$(19,906,000)	$(31,560,000)
P - Debt Service	$ 1,000	$ 1,000	$ 2,000
T - Itra-Agency Reimbursements	$ 3,000	$ 7,000	$ 10,000
Total	**$(11,412,000)**	**$(19,236,000)**	**$(30,648,000)**

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	FY 2016	FY 2017	Total
4. Revenue:			
Fund 001-C GF-Federal Medicaid Title XIX	$(20,131,000)	$(24,043,000)	$(44,174,000)
Total	**$(20,131,000)**	**$(24,043,000)**	**$(44,174,000)**

Narrative Justification and Impact Statement

What specific performance outcomes does the agency expect?
HealthPath Washington will integrate financing and services, including medical, behavioral health, and long-term supports and services, for up to 27,000 Washington citizens who have coverage from both Medicare and Medicaid. Individuals who use Medicare and Medicaid for their health and social services are among the highest risk clients of both systems. HealthPath Washington will offer care management and a person-centered approach to care delivery, through enrollment in one of two Medicare-Medicaid Integration Plans.

Performance Measure Detail
Activity Inventory
H010 HCA Healthy Options
H012 HCA All Other Clients – Fee for Service – Optional Services

Is this decision package essential to implement a strategy identified in the agency's strategic plan?
The mission of the HCA is to provide high quality health care for the state's most vulnerable residents. This request is essential to the agency's goal to improve the health of Washingtonians.

Does this decision package provide essential support to one or more of the Governor's Results Washington priorities?
This request supports two priorities of Governor Inslee, as the program holds the health plans to quality measures including community-based models of care, and will also integrate medical and mental health care.

- Pay for quality instead of quantity. Today, providers are reimbursed for office visits and procedures, which tends to create incentives to provide more care instead of better care. We must realign the financial incentives in state contracts for Medicaid and public employee health care to pay for services that make a difference while supporting similar payment models in the private insurance market that will pay for the right care in the right setting. And we must improve efforts to encourage community-based and home-based models of care for seniors and family members with disabilities.
- Integrate mental health care and medical care to treat the whole person. We will start with the care purchased by the state and encourage private purchasers to follow our lead

What are the other important connections or impacts related to this proposal?
Both programs support legislative direction as expressed by bills passed in the 2014 session. For example:

- Under House Bill 2572, Sec. 1: "The legislature declares that collaboration among state purchased health care programs, private health carriers, third-party purchasers, and health care providers to identify appropriate strategies that will increase the quality and effectiveness of health care delivered in Washington state is in the best interest of the public." In Sec. 2: "The state health care innovation plan establishes the following primary drivers of health transformation, each with individual key actions that are necessary to achieve the objective:… (b) Improve chronic illness care through better integration and strengthening of linkages between the health care delivery system and community, particularly for individuals with physical and behavioral comorbidities."
- In SSB 6312, …"contracts issued or renewed on or after January 1, 2015, including: … (H) Established consistent processes to incentivize integration of behavioral health services in the primary care setting, promoting care that is integrated, collaborative, co-located, and preventive.

What alternatives were explored by the agency, and why was this alternative chosen?
Due to the nature of the Health Home and HealthPath Washington programs, the agency explored no other alternatives.

What are the consequences of adopting this package?
Risks to Achieving Savings
The HealthPath Washington (capitated) model, once implemented, does not pose a great risk of not achieving savings. Regular population analysis by the actuaries will allow rate adjustment to address any imbalance of enrolled vs. disenrolled beneficiaries.

The cost-effectiveness of the Health Home program relies on achieving cost savings and quality metrics for the dual eligible population. Currently the major risk is not achieving high enough engagement of dual eligibles to achieve cost savings at the statistically significant level required by CMS.

What is the relationship, if any, to the state capital budget?
None

What changes would be required to existing statutes, rules, or contracts, in to implement the change?
The following summarizes the proposed RCW changes in the HCA/DSHS agency request legislation and the impact on current law:

Under RCW 48.14.0201, Premiums and prepayments tax — Health care services — Exemptions — State preemption.
Add a new clause, under 6 (b):
(ii) The healthpath Washington managed care health care delivery program administered by the health care authority and department of social and health services under chapter 74.09 RCW, which provides coordinated medicare and medicaid medical, behavioral health, and long term services and support for eligible enrollees; or

This new clause adds HealthPath Washington to the list of exemption for the premium tax.
Under RCW 48.41.030, Definitions, add a definition for HealthPath Washington:
(19) "Healthpath Washington" means a managed care health care delivery program administered by the health care authority and department of social and health services under chapter 74.09 RCW, which provides coordinated medicare and medicaid medical, behavioral health, and long term services and support for eligible enrollees.

Under RCW 48.41.090, Financial participation in pool — Computation, deficit assessments.
Add HPW to the list of WSHIP exemptions and strike language regarding the non-existent Washington Medicaid Integration Partnership:
(iii) Health plans serving medical care services program clients under RCW 74.09.035 and healthpath Washington enrollees are exempted from the calculation and from participation in the pool(~~(; and (iv) Health plans established to serve elderly clients or medicaid clients with disabilities under chapter 74.09 RCW when the plan has been implemented on a demonstration or pilot project basis are exempted from the calculation until July 1, 2009)).~~

A new section is added to chapter 82.04 RCW - Business and Occupation Tax to read as follows:
The taxes imposed by this chapter do not apply to amounts received under the healthpath Washington program that are exempt under RCW 48.14.0201(6)(b)(ii).

If the exemptions are approved it will provide needed relief for the health plans to secure valuable dollars to implement and to provide an opportunity to make the demonstration successful.

Expenditure and Revenue Calculations and Assumptions

Revenue Calculations and Assumptions:
The anticipated federal funds from Medicaid (Title XIX) are reflected in the fiscal detail.

Expenditure Calculations and Assumptions:
The projected "valley" that occurs in the 2015-17 biennium has been reduced by approximately $2 million (state funds) from the original projection, due to the lower than expected enrollment in Health Homes.

Staffing Level for Health Homes and HealthPath Washington:
Staffing at the DSHS and the HCA is required for program management, support to contractors and providers, and to assure program outcomes of improved health, reduced cost and improved quality of care.

Both strategies target the highest risk Medicaid and dually eligible beneficiaries, and require a robust network of providers and community based organizations. Implementing these models of care require ongoing staff supports to assure the delivery of the care, the quality of that care, fidelity to the model design, and evaluation of data and findings. Staff functions include:

- Contract management and monitoring;
- Fidelity and quality assurance management;
- Stakeholder and consumer outreach and engagement;

- Liaison and accountability to CMS (our federal partner for the duals demonstration component);
- Health Action Plan data collection and analysis;
- Provider One and One Health Port interactions and design; and
- Program evaluation, including multiple reports for CMS and its contractors.

The model below shows the split by Strategy for the projected expenditures in this request:

HCA - 2015-17 Biennium

Staffing Strategy 1 & 2	**FY16**	**FY17**	**Biennium**
FTE	2.0	5.0	3.5
State	121,000	335,000	456,000
Federal	121,000	335,000	456,000
Total	**242,000**	**670,000**	**912,000**

Service - Strategy 1	**FY16**	**FY17**	**Biennium**
FTE	-	-	-
State	4,074,000	(10,000)	4,064,000
Federal	4,074,000	(10,000)	4,064,000
Total	**8,148,000**	**(20,000)**	**8,128,000**

Service - Strategy 2	**FY16**	**FY17**	**Biennium**
FTE	-	-	-
State	(32,000)	(74,000)	(106,000)
Federal	(32,000)	(74,000)	(106,000)
Total	**(64,000)**	**(148,000)**	**(212,000)**

TOTAL	**FY16**	**FY17**	**Biennium**
FTE	2.0	5.0	3.5
State	4,163,000	251,000	4,414,000
Federal	4,163,000	251,000	4,414,000
Total	**8,326,000**	**502,000**	**8,828,000**

The carry-forward level in the HCA budget is:

TOTAL	**FY16**	**FY17**	**Biennium**
FTE	-	-	-
State	(4,556,000)	(4,556,000)	(9,112,000)
Federal	24,294,000	24,294,000	48,588,000
Total	**19,738,000**	**19,738,000**	**39,476,000**

Which costs, savings, and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?

Distinction between one-time and ongoing costs:

All costs in this decision package are ongoing and would continue as long as the Health Home and HealthPath Washington programs continue.

Budget impacts in future biennia:

In future biennia the federal funding percentage decreases as the program shifts from a demonstration to a fully operational program within Medicaid and Medicare.